IHS INTEGRATED BEHAVIORAL HEALTH
REQUIREMENTS VALIDATION MEETING
IHS HEADQUARTERS WEST
5300 HOMESTEAD RD, NE
ABQ, NM 87110

ATTENDEES:

Dave Atkins, Dottie Batchelder, Norman Bell, James Brown, Clare Cory, Tom Eaglestaff, Denise Grenier, Nancy Johnson, Renee LaFleur, Kathleen Manygoats, Sharon Martinez, Darwin Moore, Jon Perez, Peter Stuart, Sandra Williams, Dale Cannon, Theresa Cullen, Csaba Eghazy, Don Heim, Karen Moriah, Galen Mulrooney, Peter Burton.

OVERVIEW:

This meeting was designed to validate the integrated behavioral health (BH) use cases and validate the long-term requirements. Along with validation, time was spent capturing additional requirements and prioritizing those that exist. The meeting was also used to facilitate the development of the GUI interface to the interim solution, capture detail for the long-term model, and demonstrate four BH applications currently being used in the healthcare marketplace. Two of the applications are GOTS products (VA's MHA and the Navajo version of MH/SS) and two COTS products (Orion's Accurate Assessments and the Echo Group's Clinician Desktop.) The principle objective of the demonstrations was to refine, expand, and further validate the requirements gathering process.

As part of the behavioral health meetings we were fortunate to have Dale Cannon from the VA in attendance. Dale's background as a mental health professional and his experiences leading the development of the VA's MHA application added great value to our discussions. Additionally, Dale's input will no doubt affect our approach and decision making process as we move forward in our selection/development of a long-term application to meet the needs of the IHS Behavioral Health community.

FINAL DECISIONS:

- Pascua Yaqui initial assessment form will be used as the base line for the electronic long-term (Bio Psycho Social) form.
- Any assessment tool used by the IHS must specifically address adolescents and adults separately.
- Rather than including electronic versions of multiple assessment tools, a decision was made to include space to record type of tool used, date given, given by, and fields to accept up to 10 different scores. This procedure will be documented in a use case format and in the master requirements list.

CONCLUSIONS:

- Without adequate user training and without adequate technical support, successful, widespread use will be difficult to achieve.
- A concentrated marketing effort is needed to promote the use and deployment of the interim and long-term solutions.

NEXT STEPS:

- Arrange for a BH meeting to occur October 16-17. Primary purpose will be to evaluate GUI screen development, validate use cases, finalize requirement documentation, and further define user access requirements.
- Add a new code for "Jail" to the Type of Treatment code set.
- Arrange conference call to discuss shall statements/long-term requirements.
- Arrange conference call to discuss Practice Guidelines.
- Review of Case Management guidelines (possible call needed)

KEY ASSIGNMENTS

Task	Assigned To	Completion Date
Fax (42 CFR Part 2 confidentiality guidelines) and ATGS survey to Peter Burton	James Brown	08/13/02
Fax Outcome measures template and Pascua Yaqui intake assessment to Peter	Clare Cory	8/14/02
Distribute list of Activity Codes to larger group for input on what should be included in the list of activities. List should be divided into patient encounter and community needs. There needs to be a clear distinction between POV and Activity Codes. Need to ensure CDMIS codes get in there because so much of A/SA involves community involvement and community education.	Karen Moriah/Don Heim	
Add use cases to capture: • Documenting the use and results of an assessment tool. • The flow of an electronic referral when both providers do not share electronic referral capabilities.	Don Heim	
What are the HIPAA (privacy/confidentiality) requirements and how do they affect the development of the BH application? If the BH patient does not belong to me, can I see the patient record for treatment?	Peter B.	
Pull the JCAHO assessment and reassessment standards off the web. Use the documentation to help develop a Bio Psychosocial form.	Peter B.	8/15/02
Update Pascua Yaqui adolescent and adult assessment tool for inclusion into the BH long-term requirements. Include comments from the 8/14 mtg.	Karen Moriah Karen will ensure she has the most recent version of the assessment tool from Pat Nye before adding	

	comments from 8/14.	
Review federal BH clinical guidelines for inclusion in the Clinic/Case Management tool. Terry will get the guidelines from the VA. Jon Perez needs to be included in this discussion. This issue should focus on Practice Guidelines.	Peter Stuart, Terry Cullen, Clare Cory and group. Focus on guidelines for high volume/high risk issues POV's to include: • Depression/Anxiety • Schizophrenia • Alcohol • PTSD Schedule phone conference for Sept 6th 1:00 pm Arizona time.	
Forward requirements used for the Asthma package to Don to capture the requirements.	Terry Cullen	
Rewrite the ARCH6 requirement located on the Master Requirements List and submit to Don Heim.	Terry Cullen	
Investigate the requirement to automatically display the suicide surveillance form. Should logic be built into the system to display the form based on key fields or should the form be displayed on request? Is the interim GUI version going to be used by <u>providers only</u> or by providers and data entry personnel? Can AI prompts to a provider be turned off, especially when used by data entry person?	Galen Mulrooney	
Schedule next BH meeting for Oct 28 & 29	Peter B.	
Case Management guidelines to be reviewed with suggestions for inclusion into the application.	Denise Grenier. Possible Tele-conference.	
Collect and compile application demonstration surveys.	Csaba	8/21/02
Send email to Lori Butcher to include "Level of Understanding" to the Patient Education section of MH/SS v3.0. MH/SS reports must reflect the added value.	Peter B.	
Teleconference to finalize the Shall Statements. Participants should review requirements document before participating.	Peter B. Wednesday, September 4 9:00 – 11:00 (Arizona). Clare Cory is unavailable.	8/22/02

INTEGRATION ISSUES (DON'T LOOSE SITE OF THESE ISSUES)

Although these issues will not be specifically discussed during the August behavioral health meetings, they do represent important issues that should remain at the forefront each time the long-term solution is discussed. As a group, we must ensure that when we discuss the long-term requirements that we address and include a response to each issue.

1. RCIS Interface Requirements
2. Treatment Plan Template
3. Performance Requirements (Response, max users)
4. Artificial Intelligence
5. Progress Notes
6. Wellness Scale
7. ~~Satisfaction Survey~~ *Decided that a customer satisfaction tool would be too lengthy to capture, too involved after a person has spent hours completing forms, who'll want to complete another.*
8. Cognitive Status tool
9. GPRA reporting
10. PCC+ Integration
11. Alcohol encounter info
12. Access to RPMS and ability to export the data. How do we accommodate the needs of tribal programs?
13. Training and technical support are key factors for implementation success, the BH application, won't succeed without it.
14. Should this system use the RPMS scheduling package or should we create a scheduling package just for the BH package. Should accommodate Individual, Family, Group Appointments, Time increments (site defined). Track walk-in, scheduled, no-show, etc. Generate a non-compliance report for those who are no-show and are being required by law to participate. Will need to address the continuum of care.
15. If a site is going to become a BH provider, 42 CFR part 2 are the guidelines which must be met.

USE CASE VALIDATION FOR KEY BEHAVIORAL HEALTH PROCESSES - Refer to your handouts for detail on the Use Case Scenarios.

Use Case 20.0 - Identify a Patient

Step 2. tribal programs search using (First-Middle-Last) initials + date of birth e.g. ABC112255.

Step 5. include Patient Record Number and Aka. Also known as.

Extension: add to Face Sheet. Quantum of Indian Blood, CIB = Content of Indian Blood, Power of Attorney and who it is, Age, Last Date of Edit, Next of Kin. Delete Transgender, other.

Business Rules #3: eliminate clinical histories

Notes: Providers/Clerks may view patient data for deceased patients if assigned the appropriate security key.

Use Case 30.0 – Add an encounter

Trigger needs to be changed; current trigger was copied from Use Case 20.0

Step 10:
Remove the word 'primary'.

Step 12:
Contact demographics:

1. Delete 'Community Education', add medication review

Clinical Data Items:

1. Clinical Ability to capture CPT codes for procedures codes. Get interpreter used back in there. Some grants require specific Prevention Activity reporting. This is why we capture the Prevention activity codes. Must make sure we distinguish between Prevention Activities and alcohol programs which treat alcohol patients with prevention activities.
2. SOAP notes: SOAP is simply a method of capturing progress notes… a standardized process.
3. Progress notes: progress notes are a result of the treatment plan. These notes address the areas you feel the patient is having problems. Regardless of the method of capturing the notes they must relate to the treatment plan.
4. Need a summary page showing most recent diagnosis codes (Axis 1-5)
5. Ability to capture participants in a family session. Should be able to capture by name or by relationship to patient.

Sub Flows – Group Meetings
For repeating group meetings that contain identifiable clients, the system shall provide the ability to create a group and identify the individuals normally attending the group. The individuals comprising the group may be known to the system or may be free-text (the free-text may contain a name or a relation, e.g., Mother, Probation Officer). For a given group encounter, the system shall provide the ability to enter the date, provider, time involved, and a short narrative. The individuals who attended the encounter can be chosen from the group. For each of the attending group members who are also known to the system, the system

will provide the option to copy the group encounter information into the patient's BH record. The system shall provide an individual free text field for each member of the group.

For Assessment tools, a tab will exist that will take us directly to an assessment tool of the provider's choice. Might want to use the SOAP note open field to access the assessment tools. Have the assessment tool accessible form the SOAP note and a separate tab.

Business Rules:

Step 7:
Treatment plans will be covered in another discussion. Look to the Orion application for a good example of an automated treatment plan.

Add logic that prompts the user to close the chart if no progress has been made on a chart for a specified amount of time.

For Alcohol/Substance Abuse programs (RTCs). A flag is needed to remind the provider to follow-up with a patient. Once a patient has been discharged, the tickler file begins counting and will alert the user that a follow-up visit is needed.

Use Case 55.0 – Add a Non-Patient Encounter Record

Current list of Activity and POV codes does not accurately represent the integrated behavioral health community; specifically, the needs of the A/SA community. Currently, the focus of A/SA is to provide education in the community and keep people out of the RTCs or YRTCs.

Use Case 40.0 – Process a Patient Referral

Add 'Print Capabilities' to the use case.

As a pre-condition both facilities must be using RCIS and the BH application for providers to share and update each other's referrals. (I don't believe RCIS is necessary for in-house referrals).

Business Rules

Rule 5
should be a configurable field so that a provider can request a quick reminder for a patient with real problems, high risk. However, should not so critical if the patient is low risk.

Rule 4
delete this rule, no edits are required after it has been closed.

Notes 1
Make this an optional field.

Notes 2
A consent form must be signed for release of patient information.

Use Case 50.0 – View/Edit Patient Referrals

Mainflow

Step 3
Change term 'completed' to 'closed-out'. Add additional parameter for Purpose of Referral/Visit.

Step 4.
Include POV and display as date initiated/name & health record number/age/gender/POV/requesting provider/receiving provider/status (open-or-closed)

Add provider surrogate functionality to BH application so that provider's current workload can be assigned to another provider, giving that provider access to patient records

Need the capability to provide for an electronic signature. Once the provider completes the record and electronically signs the document, the record is complete and a provider can only add an addendum to the record, a provider cannot edit or delete a completed record. Until the electronic signature is applied, the record can be edited.

Use Case 10.0 – Generate Behavioral Health Case Management Report

Include method for case management in the long-term solution. It is important for continued funding and support to capture case management and resource use, where are resources spending their time.

Clinic/Case Management – tool needed to pull data from RPMS and direct users to perform certain tasks based on detailed guidelines set by the provider.

In addition to this report, a review of standard practice guidelines is needed. Users need a Patient/Provider/Clinic case management tool. There is a need to know how patients are doing, the interaction between providers and patients, and clinic activity.

Is it possible to develop customized reports using tools such as Access or Excel? Most likely not but the user group should look at the diabetes Case Management package as a model. There should be a case management component added onto the package for reporting purposes.

Input Parameters: Date Range, Patient Name, Diagnosis/Diagnosis Type, Medications/Med Type, Dept/Discipline/Clinic, Age Range, Gender, Population (population taxonomy)

Report Layout.

Patient ID Info	Date Range			
	# of visits	# of no shows	# of visits	# of hours of clinical	meds prescribed
Provider					
Provider 2					
Provider 3					

We will develop guidelines for the following BH problems, these are the high volume/high risk problems: Depression/Anxiety, Schizophrenia, Alcohol, PTSD.

BEHAVIORAL HEALTH BILLING REQUIREMENTS DISCUSSION

As resources continue to be depleted and sites are asked to become more self-sufficient the ability to quickly and accurately bill for services has become a very high priority for the behavioral health community. Sharon Martinez from the Santa Clara clinic attended the August BH meetings and spoke to the group about BH billing and discussed the following issues:

For 3rd party billing to generate a bill, the following data must be available:

- Patient ID
- Diagnosis (specific)
- Time spent with patient
- Dates of service
- Provider of Service

Also, providers should check on the following:

1. What is permitted to be billed by state
2. What agreements are in place with private insurance carriers
3. Exactly what coverage is the patient entitled (Private, Medicare, Medicaid)
4. Fee schedule
5. Specific state codes

Other requirements:

1. Currently, visit data must be linked to PCC+ or directly to 3rd party billing in order for a bill to be generated.
2. Potentially eligible patient visit data should automatically link to the billing package.
3. The system should perform edit checks against an encounter before it is submitted to determine if all required fields for billing are completed.
4. Specificity is key to accurate billing and reimbursement.

OUTCOME MEASURES DISCUSSION

Pat Nye initiated the discussion on Outcome Measure during our June meeting; however, at that time no detail was captured. During the August meeting Outcome measures were defined as being specific to individuals not to a group. Many times outcome measures are captured in treatment plans or are customized by site. The long-term behavioral health application will address outcome measures in two ways.

1. Will provide a method for capturing a simple outcome measure matrix
2. Will provide a method to configure a custom outcome measures document and report on that data

RCIS INTERFACE

The BH WG wants both referral systems to talk to one another so that documentation only has to be entered into one system. Data in one system is then used to populate others. Different sites have different people who key the referral data (nurses, clerks, providers, etc)

ASSESSMENT TOOLS DISCUSSION

The BH community uses many types of assessment tools to document, evaluate, and place a patient… too many to include in the long-term solution. To address the issue a drop down menu will exist to capture the tool used, the date administered, up to 10 separate scores, and a free text summary field to capture any outliers or a description of a score that is either very high or very low.

Tools must distinguish between Children and Adults.

Need the ability to print hardcopies of an assessment tool in addition to online entry.

JCAHO – has (minimum criteria) that should be used to capture Psychosocial data. JCAHO specifies categories and it is dependent on the individual sites to add detail if needed.

To capture results from the numerous assessment tools a decision was made to capture the following information. Type of tool, date it was given, by whom, and a space for 10 separate scores.

Types of tools currently used:

- Bio Psycho Social (general intake) The Pascua Yaqui Initial evaluation form for adolescents and adults developed by Pat Nye was used as a base line. With a few changes that Pat Nye is currently implementing, the survey is CARF compliant. The BH WG discussed this form in depth… modifying and adding as needed. Karen Moriah agreed to get the latest tool from Pat Nye and she will update with modifications from the WG.
- Mental Status/Mini Mental Status
- Adaptive Skills

Alcohol / Substance Abuse

- SASSI has 10 scores
- ASI
- SUDDS

Mental Health

- Cognistat or something to measure ‘cognitive’ abilities.

USER ACCESS MATRIX REVIEW

Time did not allow for this review.

MODIFICATIONS TO MASTER REQUIREMENTS LIST

The master requirements document lists the long-term requirements as a series of "Shall" statements. The document will eventually be used in the selection and/or development of the long-term solution. In reviewing the document, the following modifications were requested along with a follow-up meeting to complete the evaluation.

1. Search/Replace Case Management with Clinic Management
2. ARCH 6 being rewritten by Terry Cullen
3. INP5, add Axis 5
4. INP8 we need a way to use the text utility function to view an image. If we receive a hardcopy document, we need a way to image the document and view it.
5. INP16 modify to get rid of patient specific data. 16 should be for a generic community program where we don't care who attended the training in the high school gym.
6. INP9 if one of the following POV is keyed (Suicide Ideation/Gesture/Attempt) pop up the suicide form for completion. Need to have a method of checking for duplicates.
7. INP6 add last 15 diagnosis for the patient and all the provider to select from the list.
8. INP23 delete "for a patient"
9. INP24 insert "served" to number served.
10. INP25 delete this requirement
11. INP28, delete office, it should just be Administrative. Add correctional facility, nursing home. This should be a pop-up list for location.
12. INP35 EMTALA is a big issue and this issue needs to be reviewed for inclusion and whether it needs to be addressed.
13. INP36, add Aka. And the ability to search by initials and DOB e.g. PFB102762. and the field will not be restricted by the SOAP format.

APPLICATION DEMOS

The principle objective of the demonstrations was to further the requirements gathering process currently being conducted at IHS and was not an evaluation of vendor products. The intent was to get participants to think 'outside the box' and many of the strengths identified will become requirements for the IHS long-term solution. Captured in the minutes are brief thoughts about the strengths and weaknesses of each application as they apply to IHS BH concerns.

Orion/AccuCare (Csaba and Sandra)

- Diagnosis codes do not appear on many of the screens nor do they appear on the reports. This is a big issue for the IHS, the providers want to see the Diagnosis codes.
- What is not clear is what comes with the Accurate Assessments tool and what must be captured through the purchase of a separate module.
- Accurate Assessments was designed to limit the use of the mouse and increase the use of the keyboard. Use of a mouse tends to make an application impersonal.
- Help file exists by pressing [F1] in any open field. Displayed will be suggested ways to ask the question and what some of the responses might be.
- Must search for a diagnosis by a code, cannot search by a brief description.
- Placement recommendations will be made based on the results of the assessments.
- Capturing outcomes measures is one of Accurate Assessments greatest strengths.
- Customizable tracking mechanism for patient follow-up care. Date parameters can be set to prompt the provider or clinic to take some action when a follow-up visit is due. There is a 5-year follow-up schedule.
- Provider can enter notes and then populate those notes to all participants within an identified group.
- Custom comments can be attached to individual members within a group in addition to the canned notes.
- Billing product is called SOS. It can be deployed on site or Orion can bill for the client.
- All billing is done electronically so it remains in compliance with all federal regulations. System can handle up to 5000 claims a day and was designed specifically for behavioral health. Orion is reimbursed by what is billed and collected and payment to Orion ranges between 7.5-12.5% of collected dollars and is based on volume of billing. That is, the more that is billed and collected the less the percentage. $5000 per license.
- Orion also sells just the billing service, sites are not required to use Accurate Assessments nor SOS.
- Orion will make a site visit to assist the site get prepared and use the billing service.

Demo MH/SS Navajo (Peter Stuart)

- Don't under estimate the value of the RPMS integration of data and the ability to share data with the other RPMS applications.
- There are a lot more inquiry options in the Navajo version when compared to MH/SS v2.0.
- Navajo allows the user to customize what is seen in the health summary. Any value RPMS captures can be added as an item to be viewed in the health summary.
- Last number of visits defaults to 5 but can be altered to search more than 5.
- Add a drop down list of medications to be prescribed so that a provider does not have to type and correct spelling of prescriptions.
- Navajo has the ability to customize the labs most commonly ordered so that a provider does not have to scroll through an entire list of labs available.
- There is no limit to the number lines of text that can be loaded into a notes field.
- Ability to cut & paste from word into MH/SS. Can a text be added to prevent toggling between Word and MH/SS.
- Has the ability to create a treatment plan with start date and date for completion, goals, objectives, signatures, etc.
- Patient education can be captured; although, level of understanding is missing.
- Dave Atkins should review the Navajo package more closely, what else is required to meet the needs of A/SA users.

Demo VA MHA (Dale Cannon)

- There is a lot of value in using what you have now, what works, what integrates. Many times when we try to integrate COTS & GOTS packages we run into compatibility problems. The VA's MHA name space has not been used by the IHS so the IHS could load the MHA package without having to implement systems changes.

- The IHS uses CPRS to view patient visits, problem lists, lab, vitals. The VA mandates the use of specific packages. Different locations do not share the same server. So, as a patient, if I go from New York to Los Angeles, my data cannot be pulled up. There is one VA clinical database. Any notes you write in an application is shared with all applications. You can create a document type and then limit access to a specific type.

- Access to data continues to be a large concern for the IHS because so many of our facilities are community based clinics. Many times information will not be shared if someone feels that data might be shared. Can also restrict access to specific patient records. If someone continues on and reviews the record a message is sent to the site security manager.

- Can develop and distribute national reminders. This reminder will be exported to every site, the site can modify the reminder to be site specific, specifically for assessment tools, screening tools.

- Paper pharmacy and lab results are primarily electronic at the VA. Paper is avoided and an effort is made to ensure all documentation is available in an electronic format.

- VA does not have 'Treatment Plan' software. In most cases they pull data from the progress notes to go into a treatment plan template.

- CPRS and MHA are used specifically for the clinician's interaction with a patient. There are no administrative features contained within these packages. These two applications are specific and proud to be on the clinician's desktop software to be used specifically by the clinician.

- For Billing purposes, all the data is captured in CPRS but the billing is done outside the package, it is specific to clinician work. Again its purpose is for one clinician, one visit, one encounter.

- MHA allows a provider to **Order Tests, ASI, GAF** it is a totally separate executable much like the IHS's Patient Chart and MH/SS.

- For test results we see: tests given, a graph of the results, and a textual description of the results. Could save the results as either a graph, excel spreadsheet, or textual file. There are many different ways to view data after a test is given. The user can compare results, during different time periods, for different categories.

- The VA categorizes psychological tests into two categories (exempt and non-exempt). The VA uses security keys to allow access to tests and test results and that access is provider specific. Access is determined by the Chief of Psychology to determine who should have access to a non-exempt tests.

- Do not try to include a test into your application if you don't have a license to include it.

- The VA pays for licenses and pays a royalty to the company each time the test is used. New testing methodologies can be added to MHA. Tests can be added and deleted and persons ability to order tests is determined by their (exempt/non-exempt status.)

- Over 90% of the psychological tests at the VA are done online, language may be a barrier but computer skills are not. It does work, the VA's experience with online testing has been very successful.

- At the VA an ASI is not an official ASI until the provider adds an electronic signature. Once the signature is added, data cannot be changed, only appended.

- The ASI is mandated at the VA. Currently, it takes about one hour to complete an ASI, it takes a lot of time and people are starting to complain. The VA is now using the ASI-MV (multimedia). This is a COTS product that the VA pays for to capture ASI data and it usually runs about $6 – 8 dollars per test. A study is now taking place to evaluate the effectiveness of the ASI-MV package.

Demo Echo Software (Csaba and Natalie)

The Echo group has been around 21 years. They just acquired 7 companies. The current version v4.20 has been out since 1997 in a windows version and in a DOS version before that. A client server application very much like a windows based application and it is fully configurable with the ability to generate reports, treatment plans, pick lists, etc. This application seems to meet all of our current requirements. It is a great standalone application.

- Staff time and client time are captured separately
- Ability to scan an image of a document and display that image.
- Ability to add a note to progress notes and to treatment plans, using a template or not, and using Word or using the comment note pad
- Able to add as many survey tools as we would like. Echo will initially configure the application with particular tools loaded. We are able to create customized tools and we can add free text for any question. Also has the ability for online testing
- Training time is approximately 2-3 days for the clinical application, Echo provides this training. The technical training is much more in-depth and takes more time
- Ability to quickly capture the patient history of tests in a graph and it can be expanded to compare multiple patients to one another
- The Artificial Intelligence component of this application is configurable for each site. Not really AI but will start us down the path. Currently, the information pushes us to start answering some generic questions. Can also be configured to prevent certain provider types from keying particular procedures or diagnosis. Helps to ensure accurate visit data
- Billing package, configurable based on who we participate with, what their rules are, etc. Can configure the billable services. Has a lot of internal intelligence that will validate whether a claim is billable or not before it is billed, essentially psuedo adjudication. The system has been tried and validated to ensure its operation.
- For client specific visits simply leave the client field blank.